CONFIDENTIAL MEDICAL INFORMATION FORM

To be completed by each Participant and Advisor

Name_____Birth date_____Age____ ❑ Student ❑ Advisor ❑ Chaperone

Family Physician_____Phone Number_____

Father's Name_____Mother's Name_____

Address_____Address_____

Phone Number_____Phone Number_____

Emergency Contact Person_____Phone Number_____

Address_____

Name of person who is responsible for your medical bills (Guarantor)_____

Guarantor's relationship to you_____Guarantor's Social Security Number_____

Guarantor's Employer_____Phone Number_____

Employer's Address_____

Insurance Company_____Plan Number_____

Insurance Company's Address_____Group Number_____

_____Insured ID No._____

Do you have any known allergies? No_____Yes_____If yes, what are you allergic to?_____

When did you last receive a Tetanus shot?_____

Do you have any history of allergies, heart condition, diabetes, asthma, epilepsy, rheumatic fever, or other existing medical conditions? Explain:_____

Are you taking any medication? No_____Yes_____ If yes, what kind?_____

Do you have any physical restrictions? Explain:_____

If you **do not** have any medical insurance, sign here:_____

(Signature) (Date)

PARTICIPANT: Photocopy your insurance card (front & back) and attach it to this medical form.

Participant's signature	Date

Harold Nevill♦ State Advisor ♦ P.O. Box 83720 ♦ Boise, ID 83720-0095 ♦ Phone (208) 334-3216 ♦ Fax (208) 334-2365